4395. INAPPROPRIATE PLACEMENT OF MENTALLY RETARDED PERSONS IN SNFs AND ICFs.

It has been estimated that up to 10 percent of the residents of SNFs and ICFs are mentally retarded persons. The appropriateness of many of these placements has been challenged by groups who represent these individuals. These groups are concerned that as a result of inappropriate placement many retarded persons in general care facilities are not receiving the developmental services they need.

Inappropriate placement may result from inadequate evaluation, incorrect diagnosis, or lack of needed programs or facilities. When inappropriate placements continue to be made because of the absence of suitable alternative care, this removes much of the incentive to develop those alternatives. These problems have been compounded by pressures to deinstitutionalize the residents of large facilities. The developmental needs of mentally retarded persons place a particularly compelling responsibility on the facilities, inspection of care teams, and facility surveyors to assure that the placement of these individuals is appropriate and that needed services are, in fact, delivered.

This section emphasizes the need for appropriate placement to satisfy the developmental needs of mentally retarded individuals. If the primary need of a mentally retarded person is active treatment for his/her retardation, then the person should be placed in an ICF/MR. Chronically handicapped persons who are stable but who have severe disabilities have sometimes been placed in nursing homes not because their conditions preclude them from living in another environment but because continued coverage under Medicaid is sought.

Only a small percentage of mentally retarded persons would appropriately be placed in SNFs. This group would include those individuals whose physical condition requires skilled medical care on an inpatient basis that cannot be provided in an ICF/MR or other type of facility or home. It should be stressed that even when the primary needs of retarded persons in SNFs are medical, their developmental needs must still be met by the facility to the extent allowed by the individual's overall physical condition. In most cases, however, if their medical needs are so great that SNF care is required, the patients will not generally be well enough to receive a typical program of a wide spectrum of developmental training, especially if it is provided outside the facility. In such cases, the facility must still aggressively pursue those areas of intervention needed, (e.g., gustatory stimulation, range of motion, toilet training as possible). A patient well enough to attend outside training would nearly always be well enough to be placed in an ICF/MR or other appropriate setting. 42 CFR 456.609 indicates that the inspection of care team must determine whether the services available in the facility promote the patient's maximum physical, mental, and psychosocial functioning. If retarded residents are not receiving the care described above, this requirement would result in a negative inspection of care finding. Continued general acceptance of the inappropriate placement of retarded persons in nursing homes is unacceptable.

Another small group that may appropriately be placed in a general care facility would include those mentally retarded persons of advanced age for whom developmental training is no longer appropriate. These persons may appropriately be placed in an ICF if institutional care is required. This decision must be made on an individual basis rather than at an arbitrary age because some elderly retarded persons benefit greatly from continued developmental services.

Providers should be aware that failure to comply with the above mentioned regulation governing the appropriate placement of mentally retarded persons in SNFs and ICFs could affect Federal reimbursement. Utilization Review is a State plan requirement and disallowance of payment may be made to correct this problem; inappropriate placement may also jeopardize the "approved" status of a State plan. Section 2363 of the Deficit Reduction Act of 1984 (Public Law 98-369) has altered the requirements relating to UC penalties and has made some items previously subject to UC penalties (i.e., certification and recertification of the need for care, plan of care, and utilization review) State plan requirements not subject to the penalties. However, these requirements may still be the subject of disallowances. Utilization Control penalties are also still in place under the Inspection of Care provision and such penalties may be imposed where findings of inappropriate placements have been cited and not corrected.

4396. APPLICATION OF THE EDUCATIONAL SERVICES EXCLUSION IN ICFs/MR.

- A. <u>Background.</u>--Medicaid payment may be made only for "medical assistance" and not for the services covered as educational services under Public Law 94-142 (The Education of the Handicapped Children Act of 1975). ICF/MR services must be distinguished from "educational services" because FFP is not available for "educational services." The regulatory educational services exclusion in 42 CFR 441.13(b) that relates to individuals in ICFs/MR was intended to avoid Medicaid expenditures for categories of services funded by the States exclusively or through other funding sources as well as to preclude payment for services which are not health-related.
- B. <u>Guidelines for use in Distinguishing Educational Services.</u>—Problems that have arisen in connection with the application of the exclusion have been the result of an attempt to make the distinction between ICF/MR services and education services solely on the basis of the nature of the services, that is, to determine which services are always educational and which services are always ICF/MR services. For the reasons discussed below, this method is of limited usefulness and must be supplemented with other criteria for making the determination.

The basic approach to determining whether services provided to individuals under age 22 are educational services or are ICF/MR services is to know what is required under the State and Federal laws governing education and the contents of the Individualized Education Plan (IEP) for each individual. Services which are required under education laws will not be reimbursed under Medicaid. Public Law 94-142 made Federal education funds available only to States which have a State plan under which each handicapped child under age 22 is assured of a free and appropriate public education suited to his or her needs. It also required that the course of education for the child be described in an IEP. State education laws or constitutional provisions establish additional provisions beyond those of Public Law 94-142 and its implementing regulations. These sources spell out the minimum requirements for a free and appropriate public education and define "Special Education" (34 CFR 300.14) and "Related Services" (34 CFR 300.13) in connection with these requirements. "Special Education" includes, for example, classroom instruction, instruction in physical education, home instruction, and instruction in hospitals and institutions, speech pathology, or any other related service and also includes vocational education. "Related Services" include transportation and such developmental, corrective and other supportive services as are required to assist a handicapped child to benefit from special education, and includes speech pathology and audiology, psychological services,

physical and occupational therapy, recreation, early identification and assessment of disabilities in children, counseling services, and medical services for diagnostic or evaluation purposes. It also includes school health services, social work services in schools, and parent counseling and training. Both Public Law 94-142 and the regulations make it clear that these services must be provided under an IEP and the regulations contain minimum requirements as to the contents and scope of the IEP.

P.L. 94-142 requires the provision of the services which are needed by the student as spelled out in the plan but it does not require that the State, under the rubric of educational requirements, also supply the services of parents or others who ordinarily may be expected to provide care and some types of training for the student during the time when he or she is not in school. In order to distinguish between educational and related services and what may also be appropriate ICF/MR services, it is necessary to view the services both from the perspective of the Federal and State education statutes and from the requirements that relate to ICFs/MR. The simplest example might relate to home activities designed to complement educational activities. During the course of a free and appropriate public education, an individual might receive speech therapy to assist him or her in acquiring communications skills. The cost of providing these services in the school are clearly educational costs and no FFP would be available for them. However, once the individual has returned to the ICF/MR, staff might assist the student with further speech therapy as a Medicaid reimbursable part of the active treatment regimen that the facility is required to plan and provide.

It is important to note that the "active treatment" that an individual in an ICF/MR requires and receives consists not only of the services reimbursed by Medicaid which are provided by the staff of the ICF/MR but often includes services required by the individual that are provided in disparate settings and funded through a variety of sources. The fact that a service is included as part of the individual's "active treatment" does not necessarily mean that FFP is available for it. Other factors, including the liability of another party or organization to pay for the care, must be considered. Thus, it is necessary to go beyond the nature of the services and whether or not ICF/MR standards require their provision to determine whether or not they are subject to the educational services exclusion.

The individual's IEP must describe the types and amounts of educational and related services which will be provided in accordance with State and Federal requirements. The individual treatment plan should reflect how the State is complying with education requirements and the times and locations at which those requirements are being met. All the services described in the IEP are excluded from FFP, whether provided by State employees, by staff of the ICF/MR or by others. FFP is not available for any payment to an ICF/MR for those services required by the IEP. Review of the State and Federal laws and regulations governing the provision of education and related services is needed to assure that the IEP complies with these requirements. Services required under these laws which are not contained in the IEP but are provided by the ICF/MR would also not be eligible for FFP.

For educational services themselves, experience has shown that audits can be clear cut. Educational services are often provided in facilities or areas within an ICF/MR or on its property which are specifically identified for providing these services by or under contract with the State educational agency. The cost of these services, such as salaries,

building depreciation costs, overhead, utilities, etc., would not be eligible for FFP. This would be true even if an individual did not, in fact, receive the services described in the IEP. However, whether or not educational services are provided in a specifically identified facility or area, no FFP is available for education or related services provided to a client during the periods of time the IEP requires that educational and related services be provided.

In reviewing "related services," it is necessary to determine the purpose for which the service is provided and the location where it is provided. Many of the services defined above as "related services" in connection with education services are also services which fall within the realm of "active treatment" and are required to be provided, as needed, by the ICF/MR. For example, a client's IEP might call for a period of training each day to assist him or her in holding a spoon and using it to eat. The cost of this activity would be an educational cost subject to the exclusion. ICF/MR staff may well reinforce and continue the same type of instruction before and after the formal training as part of the individual's program of active treatment. The costs the ICF/MR incurs for this activity would be eligible for FFP.

In States where a free and appropriate public education for individuals under 22 is limited to a part of the year, e.g., 210 days, it may be appropriate for the ICF/MR to provide certain services which could be considered education or related services during periods when the State educational system is not responsible for the individual. An example would be a case in which the State is not responsible to provide speech therapy activities (as a related service under the client's IEP) during the summer but the ICF/MR determined that these services were needed by the individual. The speech therapy services could be provided by the ICF/MR as part of active treatment and would be eligible for FFP.

The educational services exclusion is applicable to services which may not be listed in the IEP, as well as to persons over the age of 22, to whom the requirements of Public Law 94-142 do not apply. For example, some inpatients of ICFs/MR are developmentally disabled but not mentally retarded and it may be that a client who is able to do the work wishes to enroll in academic courses (e.g., community college courses). For persons over the age of 22, educational services would not be eligible for FFP but "related services," as discussed above, would not be excluded.

Because of the many ways that both the education and Medicaid regulations can be interpreted, we are defining educational services not eligible for FFP as those which are:

- 1. provided in the building, rooms or area designated or used as a school or educational facility; and
- 2. provided during the specific hours and time periods in which the educational instruction takes place in the normal school day and period of time for these students; and
- 3. included in the IEP for the specific student or required by Federal and State educational statutes or regulations; and
 - 4. related services provided to a student under 22 years of age.

4397. APPLICATION OF THE VOCATIONAL SERVICES EXCLUSION IN ICFs/MR

The vocational training exclusion flows from two basic interpretations of the Medicaid statute. First, that services paid for under the program must be "medical or remedial" within the meaning of the Act. Second, that Medicaid will not pay for services for which a different State or Federal program is obligated to pay. (See §§1905(a)(6) and 1902(a)(25) of the Act.)

The Vocational Rehabilitation Act (Public Law 93-112) does not mandate the provision of vocational services to all handicapped persons. It authorizes funds for the States to provide a broad spectrum of evaluation, training, job placement, and other work-related services to qualified persons. Historically, many persons with mental retardation living in residential facilities (including ICFs/MR) have been served by vocational rehabilitation programs, but these programs do not include all adult mentally retarded persons in ICFs/MR who are involved in vocational training and work-related programs. Clients living in ICFs/MR often work in off-site vocational rehabilitation programs or worksites. Some clients may work in programs at the ICF/MR that are provided by the facility. Other programs at the facility may be sponsored by the State's vocational rehabilitation unit. Thus, it may not be possible to use the funding source or the location of the services as the sole test of whether the services are vocational training services.

For persons under the age of 22, it will not generally be necessary to distinguish vocational training separately because the education services exclusion also applies to these services (see §4396). Department of Education regulations (34 CFR 300.14) implementing Public Law 94-142 specifically include "vocational education" in their definition of "Special Education." These regulations define vocational education as:

". . . organized educational programs which are directly related to the preparation of individuals for paid or unpaid employment, or for additional preparation for a career requiring other than a baccalaureate or advanced degree."

Thus, for many clients under age 22 the question of whether services may be separately characterized as "vocational training" is resolved when it is determined that the services are education services. If services are provided for under State or Federal education law or regulations or are reflected in the client's Individualized Education Plan, they are not eligible for Federal Financial Participation (FFP). Also, States may not receive FFP if services must be provided pursuant to another State or Federal program.

In the case of clients to whom Federal and State education requirements do not apply (generally those who are over age 21 or, if under 21, have entered the labor force) further distinctions are necessary. In such cases, to determine whether service costs should be excluded under the "vocational training" exclusion, the following principles must be applied:

o No FFP is available if the services are required or funded under a State or Federal vocational training program, whether or not the clients are compensated for the work;

o If the services are provided by the ICF/MR, no FFP is available when the activity in which the client is engaged is also for the purpose of teaching the client the skills to perform tasks in an employment situation.

The test of whether the purpose would relate to an "employment" situation does not relate solely to a determination about the usefulness of the activity or to whether the client is paid for the work. The test is whether the services are provided with the reasonable expectation that the client would be able to participate in a sheltered workshop or in the general work force within one year. In reviewing the activity program, the compensation level of the client, the nature of the activity, and the level of supervision necessary for the client as well as the programmatic objectives in the plan of care should be considered in making a determination as to the purpose of the program for the particular client.

Determine whether the services being provided are directly related to preparing the client for paid or unpaid employment or are instead provided to increase the overall level of functioning of the individual. For example, a number of services which consist of skills training (sometimes called "prevocational" services) may be aimed at a more general result. These include teaching a client such concepts as compliance, attending, task completion, problem solving, and safety. These services are eligible for FFP for clients over age 21 when provided pursuant to the plan of care unless included under another program funded or required under State or Federal law.

4398. PERSONS WITH RELATED CONDITIONS

A. <u>Background--General.</u>--Section 1905 of the Social Security Act (Act) authorizes optional Medicaid coverage for services in intermediate care facilities (ICFs). Section 1905(d) of the Act indicates that the term "intermediate care facility services" may include services in a public institution for the mentally retarded or "persons with related conditions" (ICF/MR). Private facilities may also participate.

Initial Medicaid regulations published in 1974 defined "persons with related conditions" by using a cross-reference to the definition of developmental disability in the Developmental Disabilities Services and Facilities Construction Act (DDSFCA), Public Law 91-517, enacted on October 30, 1970 (changed to the Developmental Disabilities Assistance and Bill of Rights Act in 1975, (DDABRA)).

- B. <u>History of DDABRA Definition.</u>—The 1970 definition of developmental disability included specific diagnoses which were considered to be closely related to mental retardation. The definition read "... a disability attributable to mental retardation, cerebral palsy, epilepsy, or another neurological condition of an individual found by the Secretary to be closely related to mental retardation or to require treatment similar to that required for mentally retarded individuals, whose disability originates before such individual attains age 18, which has continued or can be expected to continue indefinitely, and which constitutes a substantial handicap to such individual."
- 1. Since 1970, the DDABRA definition of developmental disability has been amended. In 1975, Public Law 94-103 amended the definition to:
- a. Add autism to the list of specific conditions; dyslexia resulting from a disability otherwise specified in the definition was also added;
- b. Expand the reference to "other neurological conditions" to cover any conditions closely related to mental retardation by virtue of a similar impairment or a requirement for similar treatment; and
 - c. Relate "substantial handicap" to the ability to function normally in society.
- 2. On October 1, 1978, an amendment to DDABRA, Public Law 95-602 revised the definition of developmental disability even further to read as follows:

"The term 'developmental disability' means a severe, chronic disability of a person which--

- a. Is attributable to a mental or physical impairment or combination of mental and physical impairments;
 - b. Is manifested before the person attains age 22;
 - c. Is likely to continue indefinitely;
- d. Results in substantial functional limitations in three or more of the following areas of major life activity:

- o Self-care,
- o Receptive and expressive language,
- o Learning,
- o Mobility,
- o Self-direction.
- o Capacity for independent living, or
- o Economic self-sufficiency.
- e. Reflects the person's need for a combination and sequence of special, interdisciplinary, or generic care, treatment, or other services which are of lifelong or extended duration and are individually planned and coordinated."

The 1978 amendment changed the focus of the definition from a categorical to a functional one. Thus, the revised definition included any mental or physical impairment that limits the person's functional ability in certain activities and no longer included only specific diagnoses that previously had been used to limit the definition to those impairments closely resembling mental retardation.

C. Medicaid Program Effects of Changes.--In 1974, Medicaid regulations were promulgated to implement the ICF/MR benefit under Medicaid. The DDABRA (then DDSFCA) definition of "developmental disability" was adopted for the Medicaid definition of "persons with related conditions" because it seemed to be an appropriate and convenient means of defining the term. However, when all existing Medicaid regulations were recodified, effective October 1, 1978, as part of the Department's initiative to rewrite regulations in a clear, concise, easily understandable format, the cross-reference to DDABRA inadvertently included the words "as amended" after the phrase "Public Law 91-517 enacted on 10/30/70."

This change made the definition inconsistent with other sections of the Medicaid statute. In the paragraph following section 1905(a)(19) the statute clearly excludes Medicaid payment for "any individual who has not attained 65 years of age and who is a patient in an institution for mental diseases" with the exception of individuals under age 21 in psychiatric facilities. Therefore, the statute limits Medicaid payment for inpatient psychiatric care to individuals within specified age groups in specified inpatient settings. These restrictions do not apply to ICFs/MR. Section 1905(c) specifically excludes services in an institution for mental diseases or mental defects from the definition of intermediate care facility services. Furthermore, the definition of intermediate care facility services for the mentally retarded in section 1905(d) of the Act does not include services in an institution for mental diseases.

The DDABRA definition, as amended by Public Law 95-602, caused confusion about the kind of care covered under the ICF/MR benefit.

- D. <u>Current Definition</u>.--In May 1986 HCFA established a new definition of "persons with related conditions" at 42 CFR 435.1009. This definition combines many of the features of the 1975 developmental disability definition in the DDABRA with elements of the 1978 definition. In addition, this definition of "related conditions" was designed to:
 - o Be consistent with statutory provisions of the Medicaid program;
 - o Be independent of the DDABRA definition of developmental disability; and
 - o Exclude facilities established for treating mental illness.

The definition in ¢435.1009 now reads:

"Persons with related conditions" means individuals who have a severe, chronic disability that meets all of the following conditions:

- 1. It is attributable to-
 - o Cerebral palsy or epilepsy; or
- o Any other condition, other than mental illness, found to be closely related to mental retardation because this condition results in impairment of general intellectual functioning or adaptive behavior similar to that of mentally retarded persons, and requires treatment or services similar to those required for these persons.
 - 2. It is manifested before the person reaches age 22.
 - 3. It is likely to continue indefinitely.
- 4. It results in substantial functional limitations in three or more of the following areas of major life activity:
 - o Self-care,
 - o Understanding and use of language,
 - o Learning,
 - o Mobility,
 - o Self-direction, or
 - o Capacity for independent living.
- E. <u>Discussion.</u>—Although this definition necessarily includes reference to specific individuals for whom this benefit is designed, it is important to recognize that this term is defined in the context of determining what services may qualify as "intermediate care facility services." The focus thus is on the nature of the services which are covered. Conversely, these services would not be covered if the individual did not need the active treatment provided by an ICF/MR. The determination as to who is eligible for ICF/MR care must be based on the need of each individual for ICF/MR services and not merely on the diagnosis of the individual.

The main purpose of the changes made in the definition is to prevent facilities established for the purpose of caring for mentally ill persons from participating in the Medicaid program as ICFs/MR. Such facilities would more appropriately be considered IMDs under the law and services to their inpatients between the ages of 22 and 65 excluded from payment.

Concern has been expressed that the new definition of "persons with related conditions" does not include autism, although this diagnosis had been included in one of the earlier definitions of developmental disability. Autism is a disorder which is developmental in nature and which routinely requires treatment similar to that provided to individuals who have mental retardation and persons with related conditions. In fact, the Diagnostic and Statistical Manual of Mental Disorders, Third Edition (DSM III), which is universally recognized as authoritative by the medical community, specifically classifies autism as a pervasive developmental disorder. Moreover, the DSM III indicates that only 30 percent of individuals with autism have an I.Q. of 70 or more. Further, current knowledge on the subject of autism indicates that those individuals with autism who have low cognitive ability and those who have high cognitive ability are both dysfunctional and/or retarded because of their disabilities in the areas of communication and socialization, which profoundly interfere with the activities of daily living. Thus, ICF/MR placements for individuals with this disorder are generally appropriate. There is no basis for requiring that dually diagnosed individuals be primarily mentally retarded or have any other primary condition in assessing the need for ICF/MR placement.

Concern has also been expressed that the revised definition could result in institutions solely or primarily devoted to the treatment of autistic individuals being treated as institutions for mental diseases rather than ICFs/MR. This will not be the case. A facility dedicated to the treatment of autistic individuals would appropriately be considered to be an ICF/MR. That is, the nature of the facility would be such that it is for the treatment of mentally retarded persons and persons with related conditions. Once it is participating as an ICF/MR, the treatment of some autistic individuals who are not mentally retarded but who require treatment in that facility would also be appropriate and would qualify for Federal matching funds. Thus, a facility dedicated to the treatment of all autistic individuals, whether or not previously existing, would appropriately be considered an ICF/MR. Autistic beneficiaries are covered under Medicaid and deserve ICF/MR services as appropriate to their needs.

4415. NURSE PRACTITIONER SERVICES

- A. <u>Background</u>.--Section 6405 of OBRA 1989 (P.L. 101-239) provides for the availability and accessibility of services furnished by a certified pediatric nurse practitioner (CPNP) or a certified family nurse practitioner (CFNP) to recipients eligible for or receiving Medicaid. Section 6405 amended §1905(a) of the Act. This provision requires that CPNP and CFNP services be covered to the extent that CPNPs and CFNPs are authorized to practice under State law or regulations regardless of whether they are supervised by or associated with a physician or other health care provider. You are also required to offer direct payment to CPNPs and CFNPs as one of your payment options.
- B. <u>CPNP Requirements</u>.--A CPNP is a registered professional nurse who must meet the following requirements:
- o If your State has specific qualifications for pediatric nurse practitioners, the practitioner must:
- Be currently licensed to practice in the State as a registered professional nurse; and
- Meet the requirements for qualification of pediatric nurse practitioners in the State in which he or she furnishes services.
- o If your State does not specify by specialty, qualifications for pediatric nurse practitioners, but does define qualifications for nurses in advance practice or general nurse practitioners, the practitioner must:
- Meet qualifications for nurses in advance practice or general nurse practitioners as defined by your State; and
- Have a pediatric nurse practice limited to providing primary health care to persons less than 21 years of age.
- C. <u>CFNP Requirements</u>.--A CFNP is a registered professional nurse who must meet the following requirements:
- o If your State has specific qualifications for family nurse practitioners, the practitioner must:
- Be currently licensed to practice in the State as a registered professional nurse; and
- Meet the requirements for qualification of family nurse practitioners in the State in which he or she furnishes services.
- o If your State does not specify by specialty, qualifications for family nurse practitioners, but does define qualifications for nurses in advance practice or general nurse practitioners, the practitioner must:
- Meet qualifications for nurses in advance practice or general nurse practitioners as defined by your State; and
- Have a family nurse practice limited to providing primary health care to individuals and families.

Rev. 68 4-415

D. <u>Nurses in Advance Practice or General Nurse Practitioners.</u>—In some States, State law does not specifically name nurse practitioners according to specialty, but may instead define nurses in advance practice or nurse practitioners. Generally this means the nurse has met advanced practice requirements beyond the 2 to 4 years of basic nursing education required of all registered nurses. In these States, therefore, registered nurses must meet the State requirements for nurses advance practice or general nurse practitioner, have a pediatric nurse practice limited to providing primary health care to persons less than 21 years of age, or a family nurse practice limited to providing primary health care to individuals and families.

E. <u>Coverage of Services</u>.--Your State plan must:

- o Provide that CPNP or CFNP services are furnished to the categorically needy, to the extent CPNPs or CFNPs are legally authorized to practice under State law or regulations;
 - o Specify whether those services are furnished to the medically needy; and
- o Provide that CPNPs or CFNPs, regardless of whether their services are furnished under the supervision of, or associated with a physician or other health care provider, may choose to be paid through an independent provider agreement between you and the practitioner or paid through the employing provider.

4-416 Rev. 68

4420. NURSE-MIDWIFE SERVICES

A. Background.--Section 965 of OBRA 1980 (P.L. 96-499) provided for the availability and accessibility of nurse-midwife services to women eligible for or receiving Medicaid. Section 965 was incorporated into §1905(a)(17) of the Act, with the term "nurse-midwife" defined in §1905(m) of the Act. Section 1905(a)(17) of the Act required that nurse-midwife services be covered to the extent that the nurse-midwife is authorized to practice under State law or regulations. It also required you to offer direct reimbursement to nurse-midwives as one of your payment options. In addition, the definition of a nurse-midwife in §1905(m) of the Act was limited to registered nurses who perform services in the area of management of the care of mothers and babies throughout the maternity cycle. This definition had the effect of limiting nurse-midwife services to those in this area. (Section 1905(m) of the Act no longer defines nurse-midwife for purposes of §1902(a)(17) of the Act. It is now defined by reference to §1891(gg) of the Act, which contains essentially the same definition.)

Section 13605 of OBRA 1993 (P.L. 103-66) expanded the scope of nurse-midwife services to include all nurse-midwife services authorized under State law, whether or not they are performed in the area of management of the care of mothers and babies throughout the maternity cycle.

- B. <u>Definition of Services.</u>—Nurse-midwife services include services that nurse-midwives perform within their scope of practice authorized by State law or regulations without regard to whether the services are performed in the area of management of the care of mothers or babies throughout the maternity cycle. The services furnished in managing the care of mothers and/or babies have been expanded to include services provided outside of the maternity cycle. In the case of inpatient or outpatient hospital services or clinic services, these services are furnished by or under the direction of a nurse-midwife to the extent permitted by the facility. Nurse-midwives usually work in association with obstetrician-gynecologists or other physicians to whom they refer patients with high risk conditions or complications.
- C. <u>Nurse-Midwife Certification Requirements</u>.--A nurse-midwife is a registered professional nurse who:
 - o Is currently licensed to practice in the State as a registered professional nurse;
 - o Is legally authorized by the State or regulations to practice as a nurse-midwife; and
- o Has completed a program of study and clinical experience for nurse-midwives, as specified by the State.

If the State does not specify a program of study and clinical experience that nurse-midwives must complete to practice in the State, the nurse-midwife must meet one of the alternative certification, education, and/or experience requirements specified in 42 CFR 440.165(b)(4).

D. <u>Coverage of Services for Categorically Needy.</u>—You must provide that nurse-midwife services are furnished to the categorically needy to the extent nurse-midwives are legally authorized to practice under State law or regulations. You may also choose to provide for these services for the medically needy in your State plan.

Rev. 64 4-417

4421. SERVICES FOR PREGNANT WOMEN

- A. <u>Coverage of Services</u>.--Services to pregnant women fall within three categories:
- 1. Pregnancy-Related Services.--Coverage of pregnancy-related services up to and including delivery includes all prenatal and delivery services as defined in your approved State plan. If you have a medically needy program, provide these services to medically needy pregnant women under §1902(a)(10)(C)(iii)(II) of the Act. Due to the comparability of services provisions of §1902(a)(10)(B)(ii) of the Act, make comparable services available to categorically needy pregnant women. (See §4130.) If you do not include the medically needy in your State plan, services available to categorically needy pregnant women must, under the comparability of services provisions of §1902(a)(10(B)(i) of the Act, include at least the full range of services available to the categorically needy group. You may elect to expand services only for the pregnant women group under the exception to the comparability of services requirement. (See §4130B.)
- 2. Post-Partum Services.--For the length of time specified in §§3306 and 3571, provide pregnancy-related and post-partum services available under your State plan to women who, while pregnant, were eligible for, applied for, and received Medicaid. At a minimum, provide a continuation of those services during this post-partum period that were available under your State plan to these women before the pregnancy terminated. You are not required to identify the specific treatments covered as pregnancy-related in your State plan for this post-partum period. However, list the major categories of services or any changes in services limits (e.g., inpatient hospital, physician services) that are available only as pregnancy-related services and indicate if you elect this additional coverage under the exception to the comparability of services provision for pregnancy-related services described in clause (VII) in the matter following §1902(a)(10)(F) of the Act. (See §4130B.)

NOTE: There is no FFP available for post-partum services related to induced abortions which are not federally funded.

3. Services for Conditions That May Complicate Pregnancy.—You may elect to provide services to pregnant women for the treatment of nonpregnancy conditions that may complicate pregnancy and that are not currently available under your State plan. In electing to provide these services, you need only provide them to all pregnant women covered under your plan. These services are not subject to the other comparability of services requirements. You are not required to specify in your State plan the particular treatments or conditions that are covered under this provision. However, specify the addition of any major categories of services (inpatient hospital, physician, etc.) or changes in service limits that you elect to make available only to pregnant women under the exception to the comparability of services requirement. (See §4130B.)

B. <u>Definitions</u>.--

- 1. <u>Pregnancy-Related Services.</u>--Services for the treatment of conditions or complications that exist or are exacerbated because of pregnancy.
- 2. <u>Prenatal Services.</u>--Services to a woman during pregnancy which are directed to protecting and insuring the health of the woman and the fetus.
- 3. <u>Delivery Services.</u>—Services necessary to protect the health and safety of the woman and fetus from the onset of labor through delivery.

4-418 Rev. 64

4. <u>Post-Partum Services</u>.--Services rendered to an eligible woman following termination of pregnancy for the length of time specified in §§3306 and 3571 for any health conditions or complications that are pregnancy-related.

Rev. 64 4-419

The Medicaid program (title XIX of the Social Security Act) provides medical assistance to certain categories of individuals with low income. Medicaid is jointly financed by the Federal and State governments and administered by the States. Generally, States set eligibility and coverage standards but are required by Federal rules to cover certain categories of individuals and to guarantee the availability of certain medical services. Individuals who receive cash assistance under a program authorized by the Social Security Act automatically qualify for Medicaid and are referred to as "categorically needy." States are given the option to provide certain health care and services to the medically needy (individuals whose income is more than allowed for the categorically needy, but whose incurred medical expenses put an extreme financial burden on them).

Under section 1902(a)(10) of the Social Security Act (42 U.S.C. 1396a(a)(10)) and regulations at 42 CFR 440.210, required services for the categorically needy include hospital and physician services. These same services may be offered to the medically needy as either optional or required services depending on the make-up of each individual State's Medicaid plan (reference 42 CFR 440.220). Under 42 CFR 440.230(c), a Medicaid agency may not arbitrarily deny or reduce the amount, duration and scope of a required service to an otherwise eligible beneficiary solely because of the diagnosis, type of illness or condition. Accordingly, States have received Federal matching funds in expenditures for medically necessary abortions.

Since Fiscal Year (FY) 1977, Congress has included in each HEW Appropriations Act, a provision limiting the Department's funding of abortions. Section 209 of P.L. 94-439, Labor-HEW Appropriations Act for FY 1977, (October 1, 1977 through September 30, 1978), prohibited the Department from using any funds appropriated under the Act to pay for abortions "except where the life of the mother would be endangered if the fetus were carried to term." This limitation was continued in effect by two joint resolutions, P.L. 95-103 and P.L. 95-165, that provided continuing appropriations through November 1977.

The HEW Appropriations Act for the remainder of FY 1978, P.L. 95-205, placed slightly less stringent limitations on the Department's funding of abortions during that period. That Act prohibited the Federal funding of abortions except in the following three circumstances:

- 1. Where the life of the mother would be endangered if the fetus were carried to term;
- 2. For such medical procedures necessary for the victims of rape or incest, when such rape or incest has been reported promptly to a law enforcement agency or public health service, and
- 3. In those instances where severe and long-lasting physical health damage to the mother would result if the pregnancy were carried to term when so determined by two physicians.

These limitations were enacted in identical form in the HEW Appropriations Act for FY 79.

The two joint resolutions (section 118 of P.L. 96-86, effective October 1, 1979 through November 20, 1979; and section 109 of P.L. 96-123, effective November 20, 1979 through September 30, 1980) that appropriated funds for FY 1980 further restricted the circumstances under which the Department could fund abortions. Public Law 96-123 allowed HHS to fund abortions only where the life of the mother would be endangered if the fetus were carried to term, or in instances of promptly reported rape or incest. This act did not allow the Department to fund abortions where the mother would suffer severe and long-lasting physical health damage unless one of the two circumstances existed.

The HEW Appropriations Act for FY 1978 required the Department to issue regulations and establish procedures that "rigorously enforce" the limitations on the Federal funding of abortions that were contained in the Act. Thus, since February 1978, the Department's regulations also have limited the Federal funding of abortions.

On January 15, 1980, the U.S. District Court for the Eastern District of New York ruled in McRae v. Secretary, HEW (Civ. No. 76 C 1804) and New York City Health and Hospitals Corporation v. Secretary, DHEW, (Civ. No. 76 C 1805), that provisions contained in HEW appropriations Acts since FY 1977 that limit the use of Federal funds for abortions under Medicaid are unconstitutional. On the date that it issued the rulings, the District Court stayed its judgment for 30 days, through February 14, 1980. Both the District Court and the United States Supreme Court denied the Federal government's motions to extend the stay pending appeal to the Supreme Court. Therefore, Federal funding became available for medically necessary abortions performed on or after February 19, 1980. This condition applies through September 19, 1980. The U.S. Supreme Court granted review of both the McRae and New York City Health and Hospitals Corporation cases.

Specifically, the District Court ruled that the provisions commonly refered to as "the 'Hyde Amendment' are unconstitutional as applied to abortions that are necessary in the professional judgment of the pregnant woman's attending physician, exercised in the light of all factors, physical, emotional, psychological, familial, and the woman's age, relevant to the health-related well-being of the pregnant woman." The District Court enjoined the Department from enforcing the Hyde Amendment to the extent that it prohibits Federal funding under the Medicaid program of medically necessary abortions as defined above.

The District Court's ruling also meant that States were required to cover all medically necessary abortions under their Medicaid program. This was so because States' failure to cover all medically necessary abortions in the absence of provisions limiting the Federal funding of those procedures would be a violation of our regulations on amount, duration and scope at 42 CFR 440.230. Those regulations state that Medicaid services mandated by statute and regulation may not be arbitrarily denied or reduced in amount, duration or scope solely because of a recipient's diagnosis, type of illness or condition.

On June 30, 1980, the United States Supreme Court reversed and remanded the decisions of the United States District Court for the Eastern District of New York in McRae v. Secretary, DHEW. The Supreme Court ruled that the Hyde amendment does not violate the United States Constitution and, in addition, the court ruled that the Medicaid act does not require States to cover any abortions for which Federal funding is not available.

The plaintiffs in McRae stated that they expected to file a petition for a hearing. The Supreme Court rules provided that if such a petition is filed, the effective date of the decision is stayed while the court considers the petition for rehearing. Thus, Federal Medicaid funding continued to be available for all "medically necessary" abortions, and States were required to cover all "medically necessary" abortions under Medicaid until the Supreme Court ruled on the petition for rehearing.

On September 17, 1980 the United States Supreme Court denied the appellees' petition for a rehearing in <u>Harris v. McRae</u>. The District Court received the Supreme Court's judgment on September 19, 1980 and vacated its injunction that day. This means that for abortions performed on or after September 20, 1980 Federal funds under Medicaid will be available only for those abortions that are covered under the fiscal year 1980 Appropriations Act as interpreted by our regulations in 42 CFR 441.200 et seg. FR 61598 (October 26, 1979); i.e., life of the mother would be endangered or instances of promptly reported rape or incest. (Federal funds under Medicaid are available for all "medically necessary" abortions performed during the period February 19, 1980 through September 19, 1980.) During this period the controlling factor as to whether FFP was available was the date the abortion was performed.

On October 1, 1980 the President signed a joint resolution, (Public Law 96-369) making continuing appropriations for FY 1981. Section 101(c) of the continuing resolution for fiscal year 1981 (Pub. L. 96-369, enacted October 1, 1980 and expired December 15, 1980) prohibited the use of any funds appropriated under that Act to pay for abortions, with certain exceptions. Federal funds could be used if the life of the mother would be endangered if the fetus were carried to term, or if the procedure were necessary for the victims of rape or incest when the rape was reported within 72 hours to a law enforcement agency or public health service. States were free under this appropriation to choose not to fund abortions. Section 109 of Public Law 96-536 further continued these provisions until June 5, 1981.

Section 402 of the Supplemental Appropriations and Recession Act of 1981 (Pub. L. 97-12 enacted June 5, 1981), for supplemental and continuing appropriations for FY 1981, amended section 109 of Pub. L. 96-536 and further restricted the use of Federal funds for abortions under Medicaid. That Act provided that Federal funds were only available for abortions if the life of the mother would be endangered if the fetus were carried to term. On June 9, 1981 we informed State agencies by telegram of that change.

On December 15, 1981, the President signed the "Joint Resolution Making Further Continuing Appropriations for FY 1982 and for Other Purposes" (Pub. L. 97-92). This law appropriated funds for the Department's programs for the period through March 31, 1982. Section 101 of Pub. L. 97-92 continues in effect the restrictions on Federal funding for abortions contained in the Supplemental Appropriations and Recession Act of 1981. Subsequently, on March 31, 1982, the President signed the "Joint Resolution Making Further Continuing Appropriations for FY 1982" (Pub. L. 97-161). This law appropriates funds for the period April 1, 1982 to September 30, 1982 and extends the provisions of Pub. L. 97-92 concerning abortions. Thus, no FY 1982 funds may be used to pay for abortions except where the life of the mother would be endangered if the fetus were carried to term. Moreover, States may choose not to fund abortions to the extent they deem appropriate.

TITLE XIX--GRANTS TO STATES FOR MEDICAL ASSISTANCE PROGRAMS

Section 1902, State Plans for Medical Assistance

Section 1902(a)(10) provides inter alia: (A) for making medical assistance available, including at least the care and services listed in paragraphs (1) through (5) and (17) of section 1905(a), e.g., inpatient hospital services (other than services in an institution for tuberculosis or mental diseases) and physicians' services, to all individuals receiving aid or assistance under any plan of the State approved under titles I, X, XIV, or XVI, or Part A or Part E of title IV (including pregnant women deemed by the State to be receiving such aid as authorized in section 406(g) and individuals considered by the State to be receiving such aid as authorized under section 414(g)), or with respect to whom supplemental security income benefits are being paid under title XVI;

- (B) that the medical assistance made available to any individual described in subparagraph (A)_____
- (ii) shall not be less in amount, duration, or scope than the medical assistance made available to individuals not described in subparagraph (A);
- (C) that if medical assistance is included for any group of individuals described in section 1905(a) who are not described in subparagraph (A); then

* * *

(ii) the plan must make available medical assistance. CITATION OF REGULATION

42 CFR Public Health

Part 440, Services: General Provisions

§440.230 Sufficiency of amount, duration, and scope

- (a) The plan must specify the amount, duration, and scope of each service that it provides for-
 - (1) The categorically needy; and
 - (2) Each covered group of medically needy.

- (b) Each service must be sufficient in amount, duration, and scope to reasonably achieve its purpose.
- (c) The Medicaid agency may not arbitrarily deny or reduce the amount, duration, or scope of a required service under §§440.210 and 440.220 to an otherwise eligible recipient solely because of the diagnosis, type of illness, or condition.
- (d) The agency may place appropriate limits on a service based on such criteria as medical necessity or on utilization control procedures.

Part 441, Services: Requirements and Limits Applicable to Specific Services--Subpart E Abortions.

§441.200 Basis and Purpose

This subpart implements Federal law that places restrictions on the use of Federal funds for abortions except under the circumstances described in this subpart.

§441.201 Definition.

As used in this subpart--"Physician" means a doctor of medicine or osteopathy legally authorized to practice medicine and surgery by the State in which he or she practices.

§441.202 General rule.

FFP is not available in expenditures for an abortion except as specified in 441.203.

§441.203 Life of the mother would be endangered.

FFP is available in expenditures for an abortion when a physician has found, and certified in writing to the Medicaid agency, that on the basis of his or her professional judgment, the life of the mother would be endangered if the fetus were carried to term. The certification must contain the name and address of the patient.

§441.206 Documentation needed by the Medicaid agency.

FFP is not available in any expenditures for abortions, as provided for under 441.203, if the Medicaid agency has paid without first having received the certification as specified in that section.

§441.208 Recordkeeping requirements.

Medicaid agencies must maintain copies of the certification as specified in §441.203 for 3 years under the recordkeeping requirements at 45 CFR 74.20.

4431. FEDERAL FUNDING OF ABORTIONS

Since fiscal year 1977, Congressional restrictions have been placed on appropriated funds for the Department's programs which fund abortions. Since enactment of Public Law 97-12 (effective on June 5, 1981), FFP is only available in expenditures for an abortion when a physician has found, and so certified in writing to the Medicaid agency, that on the basis of his/her professional judgment, the life of the mother would be endangered if the fetus were carried to term. The certification must contain the name and address of the patient. Congress prohibited the use of Federal funds appropriated under Public Law 97-12 and subsequent public laws for abortions for victims of rape or incest.

However, no matter which restrictions were in place when the abortion was performed or when FFP was claimed, and even if a State were under court order to pay for medically necessary abortions that were outside the scope of the various Hyde amendments, HCFA must look at the restrictions on the use of Federal funds in place at the time those funds are used to pay the States' claim to determine if Federal funds can in fact be used. For example, appropriations enacted by Public Law 97-12 excluded Federal funds for abortions performed for victims of rape or incest. Accordingly, such services cannot be reimbursed unless the State is able to establish that funds used to pay for the abortion services did not derive from these appropriations. Thus, the controlling factor is not when the abortion was performed or when FFP was claimed, but rather which Federal funds were used to pay for the abortion service. The one exception to this rule is that HCFA has paid and will continue to pay for medically necessary abortions performed during the periods October 1, 1976 - August 4, 1977 and February 19 - September 19, 1980, when the Department was under Federal court orders requiring Medicaid coverage for medically necessary abortions.

Generally, the appropriation restrictions attached to the Federal funds provided to a State at the beginning of the quarter (the quarterly estimate) are <u>not</u> controlling unless the State can show on a case-by-case basis that those particular Federal funds were used to pay the provider who performed the abortion. A State's payment for a particular abortion service is not considered identified until after the quarterly expenditure report (Form HCFA-64) is submitted. Therefore, the Federal funds used to reimburse a State for an abortion service are provided to a State after HCFA reviews the State's expenditure report and issues a subsequent supplemental grant award to finalize that expenditure report. Thus, the restrictions attached to the Federal appropriation referenced in the finalizing grant award for a given calendar quarter governs whether abortions the State paid for during that quarter are eligible for FFP. Finally, the documentation requirements specified in 42 CFR 441.206 must be satisfied before the claim is approved for payment.

Rev. 55

4432 FEDERAL FUNDING OF ABORTION RELATED SERVICES

- A. <u>Background</u>.--Since fiscal year 1977, Congress has passed Appropriations Acts that contain restrictions on the funding of abortions. Under the Supplemental Appropriations and Rescission Act of 1981, P.L. No. 97-12, FFP became available for abortions performed only where the life of the mother would be endangered if the fetus were carried to term. All subsequent pertinent Congressional measures have continued that limitation on the use of Federal funds for abortions. 42 CFR, Part 441, Subpart E specifies that FFP is available for abortions only when a physician has found and certified in writing to the Medicaid agency that in his/her professional judgment, the life of the mother would be endangered if the fetus were carried to term.
- B. <u>Scope of Services.</u>--For purposes of FFP, noninduced, naturally occurring abortions are not subject to the abortion restriction. Therefore, FFP is available for the costs associated with treating spontaneous and missed abortions. In addition, FFP is available for treating any medical problems resulting from a medically unsupervised abortion (i.e., where someone other than a physician, such as the patient, has induced the abortion), or an ectopic (tubal) pregnancy, which often results in a naturally occurring abortion and usually requires surgical removal of the fetus.
- 1. <u>Abortion Related Services for Which FFP is Not Available</u>.--FFP is not available for the costs of medically induced/performed abortions where the life of the mother would <u>not</u> be endangered if the fetus were carried to term. FFP is therefore <u>not</u> available for the costs of services <u>directly related</u> to the performance of such abortions, as follows:
- o Physician/surgical charges for performing the abortion. These charges include the usual, uncomplicated pre and post operative care and visits related to performing the abortion.
- o Hospital or clinic charges associated with the abortion. This includes the facility fee for use of the operating room, supplies and drugs necessary to perform the abortion and charges associated with routine, uncomplicated pre and post operative visits by the patient.
- o Physician charges for administering the anesthesia necessary to induce or perform an abortion.
- o Drug charges for medication usually provided to or prescribed for the patient who undergoes an <u>uncomplicated</u> abortion. This includes routinely provided oral analgesics and antibiotics to prevent septic complication of abortion, and Rho-GAM (an immune globulin administered to Rh-negative women who have an abortion).
- o Charges for histo-pathological laboratory tests performed routinely on the extracted fetus or abortion contents.

4-428 Rev. 55

- o Charges for other laboratory tests performed prior to performing the nonmatchable abortion to determine the anesthetic/surgical risk of the patient (e.g., CBC, electrolytes, blood typing).
- 2. Abortion Related Services for Which FFP is Available.--FFP is available for the costs of all services related to an abortion where the physician has certified in writing to the Medicaid agency that in his/her professional judgment, the life of the mother would be endangered if the fetus were carried to term. FFP is also available for the costs of certain specific services associated with a non-Federally funded abortion if those services would have been performed on a pregnant woman regardless of whether she was seeking an abortion. Those services include:
- o Charges for pregnancy tests which would have been performed whether or not the individual was seeking an abortion;
- o Charges for tests to identify sexually transmitted diseases (e.g., chlamydia, gonorrhea, syphillis) and other laboratory tests routinely performed on a pregnant patient, such as Pap smear and urinalysis; and
- o Charges for all services, tests and procedures performed post-abortion for complications of a non-Federally funded therapeutic abortion, including charges for a hospital stay beyond the normal length of stay for abortions and charges for services following a septic abortion, etc.
- 3. FFP Available for Multiple Medical Procedures Involving an Abortion.--Title XIX of the Act provides that FFP is paid to the States at the regular Federal medical assistance percentage (FMAP) rate for the costs incurred for covered medical services. Conversely, FFP is not available for the cost of noncovered services. The statute further provides that FFP is available at the rate of 90 percent for the costs of family planning services.

When multiple procedures are performed during a single hospital stay or clinic visit, you must distinguish between costs attributable to an abortion or other procedure matched at the FMAP, and those attributable to a family planning service, such as a sterilization. You must then determine whether each of the procedures meets applicable Federal requirements for FFP. To the extent that a procedure which does <u>not</u> meet Federal requirements extends the hospital stay or course of clinic treatment, that portion of the claim may not be submitted for FFP. In addition, all ancillary services related solely to the procedure which does not meet applicable requirements for FFP must also be deleted from the claim for FFP.

For example, if during a hospital stay for an FFP eligible abortion, a sterilization is performed which does <u>not</u> meet Federal requirements for FFP and which extends the hospital stay, the costs associated with the sterilization and the extended hospitalization must be deleted from your claim for FFP. Similarly, if the abortion itself does not meet Federal requirements but the sterilization does, the costs which are normally attributable to the

Rev. 55

performance of the eligible sterilization may be claimed for FFP. However, use the criteria described in §§4432.B.1 and B.2 to determine whether the various services related to the FFP ineligible abortion could be claimed for FFP.

4. Exclusion of Claims for FFP for Services Related to FFP Ineligible Abortions.--Each State must have appropriate procedures for identifying abortion related services. Each State needs a method for determining whether physicians' and laboratory services, pharmaceuticals and anesthetics associated with a hospital stay or clinic visit during which an abortion is performed are related to it. Services described in §4432.B.1 related to abortions which do not meet Federal funding criteria must be excluded from claims for FFP.

Because State payment systems are not standard, there is no Federally prescribed method for accomplishing this result. Each State must devise appropriate procedures and HCFA verifies both that the procedures are in place and that they are operating properly to exclude inappropriate claims for FFP.

4-430 Rev. 55

4434. LEGAL BACKGROUND AND AUTHORITY

The Medicaid program (title XIX of the Social Security Act) provides medical assistance to certain categories of individuals with low income. Medicaid is jointly financed by the Federal and State governments and administered by the States. Generally, States set eligibility and coverage standards but are required by Federal rules to cover certain categories of individuals and to guarantee the availability of certain medical services. Individuals who receive cash assistance under a program authorized by the Social Security Act automatically qualify for Medicaid and are referred to as "categorically needy." States are given the option to provide certain health care and services to the medically needy (individuals whose income is more than allowed for the categorically needy, but whose incurred medical expenses puts an extreme financial burden on them).

Under section 1902(a)(10) of the Social Security Act (42 U.S.C. 1396a(a)(10)) and regulations at 42 CFR 440.210, required services for the categorically needy include hospital and physician services. These same services may be offered to the medically needy as either optional or required services depending on the make-up of each individual State's Medicaid plan (reference 42 CFR 440.220). Under 42 CFR 440.230(c), a Medicaid agency may not arbitrarily deny or reduce the amount, duration and scope of a required service to an otherwise eligible beneficiary solely because of the diagnosis, type of illness or condition. On November 8, 1978, the Department issued final rules governing FFP in the payment of sterilization procedures for sterilization under certain federally assisted programs. In order for FFP to be available for hysterectomies, the rules included the following requirement:

- 1. Federal funds are not available for hysterectomies performed solely for the purpose of sterilizing the patient;
- 2. Federal funds are available when a hysterectomy is being done for a reason other than sterilization provided that:
- a. The person securing authorization to perform the hysterectomy informs the patient, and her representative, if any, orally and in writing, that the operation will make her sterile; and b. The patient, or the representative, signs a statement acknowledging receipt of the information.

The statement referred to in item 2b is commonly referred to as the "acknowledgment statement."

The regulations were developed to safeguard patients rights by ensuring that women will make informed and voluntary choices; and to emphasize that hysterectomies are not an appropriate or acceptable means of sterilization.

On August 4, 1982 the Department published final regulations in the <u>Federal Register</u> which amend the hysterectomy requirement. The regulations eliminate the need to inform women who are already sterile or who require a hysterectomy as an emergency life-saving procedure, that the hysterectomy would render them incapable of reproducing. The amended regulations were effective upon publication. In addition, if a State so chooses, the regulation can be made retroactive to March 8, 1979, when the initial regulations became effective, or any date thereafter through the date of publication of these regulations.

TITLE XIX--GRANTS TO STATES FOR MEDICAL ASSISTANCE PROGRAMS

Summary of Section 1902, State Plans for Medical Assistance

Section 1902(a)(10) provides, inter alia: (A) for making medical assistance available, including at least the care and services listed in paragraphs (1) through (5) and (17) of section 1905(a), e.g., inpatient hospital services (other than services in an institution for tuberculosis or mental diseases) and physicians' services, to all individuals receiving aid or assistance under any plan of the State approved under titles I, X, XIV, or XVI, or Part A or Part E of title IV (including pregnant women deemed by the State to be receiving such aid as authorized in section 406(g) and individuals considered by the State to be receiving such aid as authorized under section 414(g)), or with respect to whom supplemental security income benefits are being paid under title XVI;

- (B) that the medical assistance made available to any individual described in subparagraph (A)---
- (ii) shall not be less in amount, duration, or scope than the medical assistance made available to individuals not described in subparagraph (A);
- (C) that if medical assistance is included for any group of individuals described in section 1905(a) who are not described in subparagraph (A); then
- (ii) the plan must make available medical assistance.... SUMMARY OF CITATION OF REGULATION

42 CFR Public Health

Part 440, Services: General Provisions

§440.230 Sufficiency of amount, duration, and scope

- (a) The plan must specify the amount, duration, and scope of each service that it provides for (1) The categorically needy; and
 - (2) Each covered group of medically needy.

- (b) Each service must be sufficient in amount, duration, and scope to reasonably achieve its purpose.
- (c) The Medicaid agency may not arbitrarily deny or reduce the amount, duration, or scope of a required service under §§440.210 and 440.220 to an otherwise eligible recipient solely because of the diagnosis, type of illness, or condition.
- (d) The agency may place appropriate limits on a service based on such criteria as medical necessity or on utilization control procedures.

Part 441, Services: Requirements And Limits Applicable To Specific Services Subpart F Sterilization.

§441.250 Applicability.

This subpart applies to sterilizations and hysterectomies reimbursed under Medicaid.

§441.252 Definitions.

As used in this subpart:

"Hysterectomy" means a medical procedure or operation for the purpose of removing the uterus.

§441.252 State plan requirements.

A State plan must provide that the Medicaid agency will make payment under the plan for sterilization procedures and hysterectomies only if all the requirements of this subpart were met.

§441.255 Sterilization by hysterectomy.

- (a) FFP is not available in expenditures for a hysterectomy if--
- (1) if it was performed solely for the purpose of rendering the individual permanently incapable of reproducing or
- (2) if there was more than one purpose to the procedure, it would not have been performed but for the purpose of rendering the individual permanently incapable of reproducing.
- (b) FFP is available in expenditures for a hysterectomy not covered by paragraph (a) of this section only under the conditions specified in paragraphs (c), (d), or (e) of this section.
 - (c) FFP is available if--
- (1) The person who secured authorization to perform the hysterectomy has informed the individual and her representative, if any, orally and in writing that the hysterectomy will make the individual permanently incapable of reproducing and
- (2) The individual or her representative, if any, has signed a written acknowledgment of receipt of that information.

(d) Effective on March 8, 1979 or any date thereafter through the date of publication of these regulations at the option of the State, FFP is available if--

(1) The individual--

- Was already sterile before the hysterectomy; or
- (ii) Requires a hysterectomy because of a life-threatening emergency situation in which the physician determines that prior acknowledgment is not possible; and (2) The physician who performs the hysterectomy--

- Certifies in writing that the individual was already sterile at the time of the hysterectomy, and states the cause of the sterility; or
- (ii) Certifies in writing that the hysterectomy was performed under a life-threatening emergency situation in which he or she determined prior acknowledgment was not possible. The physician must also include a description of the nature of the emergency.
- Effective March 8, 1979 or any date thereafter through the date of publication of these regulations at the option of the State, FFP is available for hysterectomies performed during a period of an individual's retroactive Medicaid eligibility if the physician who performed the hysterectomy certifies in writing that--
- (1) The individual was informed before the operation that the hysterectomy would make her permanently incapable of reproducing or
- (2) One of the conditions in paragraph (d)(1) of this section was met. The physician must supply the information specified in paragraph (d)(2) of this section.

§441.256 Additional condition for Federal Financial Participation (FFP).

- FFP is not available in expenditures for any sterilization or hysterectomy unless the Medicaid agency, before making payment, obtained documentation showing that the requirements of this subpart were met. This documentation must include a sterilization consent form, or acknowledgement of receipt of hysterectomy information or a physician's certification under §441.255(d)(2) as applicable.
- (b) With regard to the requirements of §441.255(d) for hysterectomies performed from March 8, 1979 through November 2, 1982, FFP is available in expenditures for those services if the documentation showing that the requirements of that paragraph were met is obtained by the Medicaid agency before submitting a claim for FFP for that procedure.

4435. STERILIZATION BY HYSTERECTOMY

Since March 8, 1979, Federal funds are not available for a hysterectomy performed solely for the purpose of sterilization. Federal funds, however, are available for medically indicated hysterectomy procedures (e.g., removal of a cancerous uterus) provided that the individual and her representative, if any, have been informed orally and in writing that the procedure will render her incapable of reproducing. The individual or her representative, if any, must acknowledge receipt of this information in writing. The original regulations did not provide any exception to the requirement for a hysterectomy procedure. The written acknowledgment is acceptable if the patient signs the statement either <u>before</u> or after the hysterectomy is performed. However, when the patient signs the acknowledgment statement after surgery, in order to meet the intent of the regulation the statement must contain language which clearly states that she was informed <u>before</u> surgery of the consequences of the hysterectomy, i.e., that it would render her sterile.

There is no specific content or format to be used for the written acknowledgment. Therefore, any document signed by the recipient or her representative which reasonably indicates that she received the required information will satisfy the regulatory requirement.

4435.1 Waiver of the Hysterectomy Acknowledgment Statement

Effective August 4, 1982, the Hysterectomy Acknowledgment statement is no longer required in the following circumstances and FFP is available when the appropriate documentation is obtained.

- A. The individual was already sterile before the operation, and the physician who performs the hysterectomy certifies that the individual was already sterile at the time of the hysterectomy, and states the cause of the sterility.
- B. The individual requires a hysterectomy because of a life-threatening emergency situation (i.e., the individual was in imminent danger of loss of life; for example, the patient must undergo a hysterectomy due to a perforated uterus or uteroplacental apoplexy) in which the physician determines that prior acknowledgment is not possible, and the physician who performs the hysterectomy (1) certifies in writing that the hysterectomy was performed under a life-threatening emergency situation in which he or she determined prior acknowledgment was not possible, and (2) describes the nature of the emergency.

4435.2 Retroactivity of the Provision Waiving the Acknowledgment Requirement

At the States' option, the waiver of acknowledgment requirement provision and other parts of this guideline (i.e., the patient or his representative, if any, may sign the acknowledgment requirement either before or after the operation) may also be retroactive to the original date of the implementation of the sterilization regulation, March 9, 1979, or any date thereafter at the option of the State depending upon whether the State or the provider is resubmitting a retroactive claim for FFP.

A. State Paid Claim For Which FFP Has Not Been Claimed

At the States' option, effective March 9, 1979 or any time thereafter through November 2, 1982 (90 days after publication of the regulation) FFP is available if, prior to submitting the claim for FFP, the State obtains written certification from the physician who performed the hysterectomy that the individual was--

1. Already sterile before the hysterectomy, and states the cause of the sterility, or

2. Requires a hysterectomy because of a life-threatening emergency situation in which the physician determines that prior acknowledgment is not possible, and include a description of the nature of the emergency.

Normally, the State may claim FFP for an expenditure up to 2 years after the calendar quarter in which the State made the expenditure. However, since this claim may be time-barred by this provision, the time limits imposed under 45 Part 95 are waived with respect to this claim until 90 days after publication of the regulations on August 4, 1982.

B. FFP Disallowed In A State Paid Claim as a Result of Federal Audit or Review

If FFP has been recouped from the State in the type of claims provided for by the waiver provision, the State must identify the claim and obtain the physician's certification before it claims FFP. The time limits normally imposed for States to submit claims for FFP are waived with respect to these claims until 90 days after publication of the regulations on August 4, 1982.

C. <u>State Paid The Providers' Claims, But Later Recouped Payment As A Result Of An Audit Or Review.</u>

If the State has recouped payment from the provider or initially denied claims under the waiver provision, the provider is responsible for identifying such claims and must submit new claims which meet the requirements of the amended provision.

For claims previously denied during the retroactive period because the Federal requirements were not met, the provider is given from the date of publication of the regulations, August 4, 1982, to whatever period of time the provider normally has for submitting claims for payment, e.g., if the providers normally have 1 year to submit their claims for payment, then for those denied claims during the retroactive period the providers have 1 year beginning with the date of publication of these regulations to submit their claims along with this documentation, and therefore the period expires 1 year from the date of publication of the regulations.

The required documentation should consist of certification by the physician who performed the procedure that the individual was sterile (stating the name of the condition) or the hysterectomy was performed due to an emergency life-threatening situation (describing the emergency).

4435.3 Retroactive Eligibility

Federal funding is available for hysterectomies performed during a period of a Medicaid beneficiary's retroactive eligibility. In order for payment to be made in these cases, the physician must submit a written statement certifying that one of the following conditions were met:

- A. He or she informed the woman before the operation that the procedure would make her sterile, or
- B. The women met one of the exceptions provided in the waiver provision. In this case the statement must describe the cause of the sterility or the nature of the emergency when one of the above conditions are met no written acknowledgment by the woman or her representative is required.

4435.4 <u>Conditions For Federal Financial Participation (FFP) to be Available in the Payment of Hysterectomy Procedures</u>

FFP is not available in the payment of a hysterectomy procedure unless the Medicaid agency, before making payment, obtained the appropriate documentation. This documentation must include an acknowledgment of receipt of hysterectomy information or a physician certification that the individual was already sterile at the time of the hysterectomy, stating the cause of the sterility, or that the hysterectomy was performed under a life-threatening emergency situation in which the physician determined prior acknowledgment was not possible and describing the nature of the emergency.

With regards to claims submitted for the retroactive period, March 8, 1979 through 90 days after publication of the regulations, FFP is available for those claims meeting the waiver provision if the State agency obtains the appropriate documentation.